



# APPLICATION FOR HEALTH FACILITY ADMINISTRATOR PROVISIONAL LICENSE

State Form 52569 (3-06)

Approved by State Board of Accounts, 2006

INDIANA STATE BOARD OF  
HEALTH FACILITY ADMINISTRATORS  
PROFESSIONAL LICENSING AGENCY  
402 West Washington Street, Room W072  
Indianapolis, Indiana 46204  
Telephone: (317) 234-2051  
E-mail: pla6@pla.IN.gov

\* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

## FOR OFFICE USE ONLY

Application fee	Date fee paid (month, day, year)	Receipt number
Date of issuance (month, day, year)	Provisional license number	

## DO NOT WRITE ABOVE THIS LINE

## APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden)		Social Security number *
Address (number and street or rural route)		
City	State	ZIP code
Telephone number (daytime) ( )	Email address	
Date of birth (month, day, year)	Place of birth	

## WORK EXPERIENCE

You must have at least two (2) years of administrative experience in a licensed health facility to qualify for a provisional license [840 IAC 1-1-14 (a)]. Please attach a complete resume documenting your administrative experience. Include your employer, position, type of business, period of time worked, duties, type of facility (SNF, ICF, etc.) and number of beds in the facility. The provisional license can only be used in the licensed health facility that is specified on page three (3) of this application.

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including the location, date and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied licensure, registration, or certification in any state (including Indiana) or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you now being or have you ever been treated for drug or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

Signature of applicant	Date (month, day, year)
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#### AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization, or institution to release to the Professional Licensing Agency any files, documents, records, or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives, in connection with the processing of my application for a health facility administrators provisional license.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations and institutions, any information which is material to my application, and I hereby specifically release the Agency, and the Board, from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

#### AFFIRMATION

I hereby swear and affirm that I have read the above statements and agree to the same.

Signature of applicant

Date signed (*month, day, year*)

**THE FOLLOWING MUST BE COMPLETED BY THE HEALTH FACILITY OWNER OR  
AN OFFICER OF THE FACILITY'S BOARD OF DIRECTORS**

This is a request for a provisional license as set out in IC 25-19-1-3 (b), which states:

*(b) The board may issue a provisional license for a single period not to exceed six (6) months for the purpose of enabling a qualified individual to fill a health facility administrator position that has been unexpectedly vacated. Before an individual is issued a provisional license, the individual must fulfill the requirements in subdivision (a) (1) in addition to complying with other standards and rules established by the board.*

**Please attach a *detailed* explanation of the reason(s) the provisional license is being requested. This information *must* be included with the application for the Board to consider your request.**

Name of prospective individual ( <i>last, first, middle</i> )			
Name of health facility			
Address of facility ( <i>number and street or rural route</i> )			
City		State	ZIP code
Telephone number of facility (       )		Number of beds in facility	
Type or level of care provided			

VERIFICATION		
I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.		
Signature of owner or officer	Title	Date ( <i>month, day, year</i> )